STATEMENT AS OF _____ OF _____

(Period Ending) (Name)

DRAFT For Discussion Purposes Only Send comments to Myamanaka@dmhc.ca.gov

GENERAL INTERROGATORIES

1. Has any change been made since the last reporting date in the charter, articles of incorporation, by-laws, or contracts with physicians, hospitals or subscribers where submission is required by a state regulation? If "Yes," attach current copies of the documents, if they have not been previously submitted. YES [ ] NO [ ]

2. Is the HMO authorized to conduct business in other states? If "Yes," list all the stated in which the HMO is authorized to conduct business: _____ YES [ ] NO [ ]

3a. State as of what date the latest financial examination of the HMO was made or is being made.

3b. State the date of the latest financial examination report that is available from either the state of domicile or the company. This date should be the date of the examined balance sheet and not the date the report was completed or released.

3c. State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the company. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

3d. By what department or departments? _____

4. Is the HMO directly or indirectly owned or controlled by any other company, corporation, group of companies, partnership, or individual? YES [ ] NO [ ]

5. List the following capital stock information for the HMO:

	No. of Shares Authorized	No. of Shares Outstanding	Par or Stated Value Per Share	Dividend Rate	Are Dividend Cumulative?
Common					
Preferred					

6. Does the HMO have an established procedure for annual disclosure to its Board of Directors of any material interest or affiliation on the part of any of its officers, directors, or responsible employees, which is in, or is likely to, conflict with the official duties of such person? YES [ ] NO [ ]

7. Did any officer, director, shareholder, or salaried employee of the HMO receive, directly or indirectly, any commission on the business transactions of the HMO? If "Yes," give particulars: _____ YES [ ] NO [ ]

8. Was money loaned during the period covered by this report to any officer, director, or shareholder of the HMO? If "Yes," give detailed explanation of each loan: _____ YES [ ] NO [ ]

9. Are officers and employees of the HMO covered by a fidelity bond? If "Yes," give name of surety company and amount of coverage: _____ YES [ ] NO [ ]

10. Were all the stocks, bonds, and other securities owned as of the reporting period, over which the HMO has exclusive control, in the actual possession of the HMO on the said date? If "No," give location: _____ YES [ ] NO [ ]

11. Is the purchase or sale of all investments of the HMO passed upon by either the Board of Directors or a subordinate committee thereof? If "No," state who has the authority: _____ YES [ ] NO [ ]

12. Has any present or former officer, director, or any other person or firm any claim of any nature whatsoever against the HMO which is not included in the financial statements? If "Yes," give details: _____ YES [ ] NO [ ]

13. Have damage claims for medical injury been initiated against the HMO during the reporting year? If "Yes," attach a complete report giving the number and amount of claims broken down into claims with and without formal legal process, and their disposition, if any. YES [ ] NO [ ]

14. Has the HMO been subject to any administrative orders, cease and desist orders, revocation orders, fines or suspensions by any government entity during the reporting year? If "Yes," give details (You need not report an action, either formal or informal, if a confidentiality clause is part of the agreement). YES [ ] NO [ ]

15. Have any other legal actions been taken against the HMO during the reporting year? If "Yes," attach additional sheets giving full particulars. YES [ ] NO [ ]

16. Does the HMO have direct professional liability coverage (commonly known as "malpractice")? If the HMO does not have this coverage, please explain. If "Yes," provide the following information: YES [ ] NO [ ]
    (a) Name of Carrier: _____
    (b) Limits of Coverage: _____
    (c) Expiration Date: _____

17. Are the providers of the HMO contractually obligated to maintain professional liability coverage? YES [ ] NO [ ]

18. Does the HMO have general liability insurance coverage? If the HMO does not have this coverage, please explain. If "Yes," provide the following information: YES [ ] NO [ ]
    (a) Name of Carrier: _____
    (b) Limits of Coverage: _____
    (c) Expiration Date: _____

19. Does the HMO have reinsurance (stop-loss) coverage? If the HMO does not have this coverage, please explain. If "Yes," provide the following information: YES [ ] NO [ ]
    (a) Name of Carrier: _____
    (b) Limits of Coverage: _____
    (c) Expiration Date: _____

20. Describe arrangements which the HMO may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other arrangements: _____
    _____

21. Does the HMO set-up its claims liability for hospital and other medical services on an invoice date basis or a service date basis? (State basis, if both, explain) _____ YES [ ] NO [ ]
    _____

22. Have there been any changes in the information filed with the Department regarding the value of the collateral used to secure affiliate receivables that are being included to calculate Tangible Net Equity as permitted by Rule 1300.76(e). If "yes," give details and indicate if the changes have been filed. YES [ ] NO [ ]

23. Provide the following information for accounts that are ten percent (10%) or more of total HMO enrollment:
    (a) Type of Account – In the table below, describe the account using one of the following terms:
        1. Federal Employees
        2. County and Municipal Employees
        3. State Employees
        4. Corporate Nonpublic-Service Sector
        5. Corporate Nonpublic-Manufacturing
        6. Union and Trust Fund (Account contract should be with a union trust fund; do not include accounts for contracts with above categories even if these are unionized)
        7. Medicaid
        8. Medicare
        9. Other
    (b) Percentage of Total Enrollment – Provide the percentage of total enrollment represented by this account.
    (c) Renewal Date – Provide the renewal date (month/date/year) for this account's contract.

(1) Type of Account	(2) Percentage of Enrollment	(3) Renewal Date
_____	_____	_____
_____	_____	_____

24. Does the HMO have business subject to implicit or explicit premium rate guarantees? If "Yes," provide the following information: YES [ ] NO [ ]

    (a) Business with rate guarantees between 15-36 months $_____
    (b) Business with rate guarantees over 36 months $_____

25. Did the HMO advance funds to any providers? If so, provide the following information:

Provider Name	Amount Due	1-30 Days	31-60 Days	61-90 Days	Over 90 Days
_____	$ _____	$ _____	$ _____	$ _____	$ _____

26. Provide the following details on reinsurance recoveries and expenses.

1 Description of Treaty, Terms, and Name of Carrier	2 Total Reinsurance Recoveries Received in Current Year	3 Total Recoveries Receivable or Recoverable for Year 200_ Claims	4 Reins. Recoveries Receivable for the prior Annual Statement (same as Col 3 in last year's schedule	5 Reins. Recoveries for Current Year Earnings (Col. 2+3+4)	6 Reinsurance Expenses
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____